United Nations A/69/256

General Assembly

Distr.: General
5 August 2014

Original: English

Sixty-ninth session
Item 27 of the provisional agenda*
Advancement of women

Supporting efforts to end obstetric fistula

Report of the Secretary-General

Summary

The present report has been prepared in response to General Assembly resolution 67/147. Obstetric fistula is a devastating childbirth injury that leaves women incontinent and often stigmatized and isolated from their families and communities. It is a stark outcome of gender inequalities, human rights denial and poor access to reproductive health services, including maternal and newborn care, and an indication of high levels of maternal death and disability. The report outlines efforts made by countries at the global, regional and national levels, and by the United Nations system, to end obstetric fistula. It offers recommendations to intensify these efforts, within a human rights-based approach, to end obstetric fistula in the days remaining for the achievement of Millennium Development Goal 5 and beyond, by improving maternal health, strengthening health systems, reducing health inequities and increasing the levels and predictability of funding.

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14-58721 (E) 190814

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I. Introduction

1. The present report is submitted pursuant to General Assembly resolution 67/147, in which the Assembly requested the Secretary-General to submit to it at its sixty-ninth session a report on the implementation of the resolution under the item entitled "Advancement of women".

2. Sexual and reproductive health problems remain among the leading causes of ill health and death for women of childbearing age worldwide.[1] Far too many women suffer disproportionately from limitations on their right of access to health care, from unintended pregnancies, maternal death and disability, sexually transmitted infections, including HIV, cervical cancer, sexual and gender-based violence, and other problems related to their reproductive system. Educating and empowering women and girls are crucial for their well-being and fundamental to improving maternal health and preventing obstetric fistula. Additional steps must be taken to ensure all women worldwide have adequate access to health care, including sexual and reproductive health services, and to address the economic and sociocultural factors that negatively affect women.

II. Background

3. Ending obstetric fistula is a core component of all efforts to reduce maternal mortality and morbidity and improve maternal health. Any woman or girl suffering from prolonged or obstructed labour without timely access to an emergency caesarean section is at risk of developing obstetric fistula. Obstetric fistula is a severe maternal morbidity and a stark example of health inequity. Although fistula has been virtually eliminated in many countries, it continues to afflict many poor women and girls in the developing world who are without adequate access to health services. In order to eliminate obstetric fistula on a global scale, it is necessary to scale up country capacity to provide access to comprehensive emergency obstetric care, treat fistula cases, and address underlying medical, socioeconomic, cultural and human rights determinants. To end obstetric fistula, countries must ensure universal access to reproductive health services; eliminate gender-based social and economic inequities; prevent child marriage and early childbearing; promote education and broader human rights, especially for girls; and encourage community involvement.

4. Obstetric fistula has an immediate health impact for a woman and her child and, left untreated, can have devastating medical and social consequences. There is a strong association between fistula and stillbirth, with research indicating that the majority of women (from 78 per cent up to 95 per cent) who develop obstetric fistula also deliver a stillborn baby.[2] A woman with fistula is not only left incontinent but may also experience neurological disorders, orthopaedic injury, bladder infections, painful sores, kidney failure or infertility. The odour from

[1] World Health Organization (WHO), "Women's health", Fact Sheet No. 334 (updated September 2013). Available from www.who.int/mediacentre/factsheets/fs334/en/.

[2] Pierre Marie Tebeu and others, "Risk factors for obstetric fistula: a clinical review", *International Urogynecology Journal*, vol. 23, No. 4 (2012), pp. 387-394. See also Mulu Muleta, Svein Rasmussen and Torvid Kiserud, "Obstetric fistula in 14,928 Ethiopian women", *Acta Obstetricia et Gynecologica Scandinavica*, vol. 89, No. 7 (July 2010), pp. 945-951.

constant leakage, combined with misperceptions about its cause, often results in stigma and ostracism. Many women with fistula are abandoned by their husbands and families. They may find it difficult to secure income or support, thereby deepening their poverty. Their isolation may affect their mental health, resulting in depression, low self-esteem and even suicide.

5. While precise figures are not available, it is estimated that more than 2 million women and girls are living with obstetric fistula.[3] Obtaining exact data for prevalence and incidence is extremely difficult given that fistula usually afflicts the most marginalized — the poor, vulnerable, often illiterate women and girls living in rural areas — and usually requires clinical screening to diagnose.

6. In order to prevent obstetric fistula, it is necessary to address the root causes of maternal mortality and morbidity, including poverty, gender inequality, barriers to education — especially for girls — child marriage and adolescent pregnancy. Hence, economic and sociocultural changes are required. Health-care costs can be prohibitive for poor families, especially when complications occur. These factors contribute to the three kinds of delay that impede women's access to health care: (a) delay in seeking care; (b) delay in arriving at a health-care facility; and (c) delay in receiving adequate care once at the facility. Sustainable solutions for ending obstetric fistula therefore require accessible functioning health systems, adequately trained health professionals, reliable access to essential medicines and equipment and equitable access to high-quality reproductive health services.

7. Adolescent girls are particularly at risk of maternal deaths and morbidities, including fistula. If a girl's pelvis and birth canal are still developing, she is at a higher risk of health problems if she becomes pregnant. Each year, approximately 7.3 million births occur among girls under the age of 18 years in developing countries, with 2 million of these births occurring among girls younger than 15 years of age.[4] Complications from pregnancy and childbirth are a leading cause of death among girls aged 15 to 19 years in many low- and middle-income countries. Recent research, however, suggests that, besides adolescent girls, women aged 30 years and older are also at increased risk of developing complications and of dying during childbirth.[5]

8. During the period 2010-2020, an estimated 142 million girls will marry before 18 years of age.[6] Impoverished, marginalized girls are more likely to marry and give birth during adolescence than girls who have greater education and economic opportunities. Child marriage is a key driver of early pregnancy and of childbearing before adolescent girls are physically or emotionally ready, which heightens their risk of maternal death and morbidity, including obstetric fistula. Married adolescent girls often have difficulty accessing reproductive health services owing to factors such as social isolation and lack of awareness of their reproductive rights. All adolescent girls and boys, both in and out of school, married and unmarried, need

[3] www.who.int/features/factfiles/obstetric_fistula/en/.

[4] *State of World Population 2013: Motherhood in Childhood — Facing the Challenge of Adolescent Pregnancy* (United Nations publication, Sales No. E.13.III.H.1).

[5] Andrea Nove and others, "Maternal mortality in adolescents compared with women of other ages: evidence from 144 countries", *The Lancet Global Health*, vol. 2, No. 32 (March 2014), pp. e155-e164.

[6] United Nations Population Fund (UNFPA), *Marrying Too Young: End Child Marriage* (New York, 2012).

access to comprehensive sexuality education and to health services, including those on sexual and reproductive health, to protect their well-being.

9. The three most cost-effective interventions to reduce maternal mortality and morbidity, including obstetric fistula, are: (a) universal access to family planning; (b) a trained health professional with midwifery skills at childbirth; and (c) timely access to high-quality emergency obstetric and neonatal care. Prevention is a core component of effective strategies to end obstetric fistula, including the eradication of poverty and inequalities.

10. Most cases of obstetric fistula can be treated through surgery, after which women can be reintegrated into their communities with appropriate psychosocial care. Research suggests, however, that there is a significant unmet need for fistula treatment. Currently, few health-care facilities are able to provide high-quality fistula surgery, owing to a lack of health-care professionals with the necessary skills, as well as essential equipment and life-saving medical supplies. When the services are available, many women are not aware of them or cannot afford or access them because of barriers, such as transportation costs. As shown on the Global Fistula Map,[7] a reported 13,858 fistula surgeries were performed in 2013. While not every identified fistula centre provided 2013 data, such numbers show that only a fraction of women with obstetric fistula receive treatment annually, particularly when compared to the estimated 50,000 to 100,000 new cases each year.[8] This highlights the need for intensifying resources to bridge this wide gap.

III. Initiatives at the international, regional and national levels

A. Major international initiatives

11. The Programme of Action of the International Conference on Population and Development, adopted in Cairo in 1994, recognized maternal health as a key component of sexual and reproductive health and reproductive rights. The Fourth World Conference on Women, held in Beijing in 1995, adopted the Platform for Action which recognized entrenched patterns of social and cultural discrimination as major contributors to sexual and reproductive ill health, including maternal death and disability. In 2013, at the request of the General Assembly, an operational review was undertaken by the United Nations of the implementation of the Programme of Action of the International Conference on Population and Development. The review recommended that States implement measures to eliminate preventable maternal mortality and morbidity, including obstetric fistula, through the provision of high quality maternal health care for all women (see E/CN.9/2014/4 and Corr.1).

12. In 2000, world leaders committed to Millennium Development Goal 5, a target of which was which to reduce the maternal mortality ratio by three quarters by 2015. In 2010, data showed that, for the first time, good progress had been made towards reaching Goal 5. The most recent United Nations estimates, however, show that only 11 countries with a baseline maternal mortality ratio of 100 or more in 1990 are on track to achieve the Goal by 2015. Some 63 countries are considered to

[7] http://globalfistulamap.org/.

[8] www.who.int/features/factfiles/obstetric_fistula/en/.

be making progress but the average annual decline of the maternal mortality ratio is insufficient to achieve it.[9]

13. In 2007, the General Assembly for the first time acknowledged obstetric fistula as a major women's health issue and adopted resolution 62/138, on supporting efforts to eliminate obstetric fistula, which was sponsored by a large number of States. Subsequently, in 2010 and 2012, the Assembly adopted resolutions 65/188 and 67/147, respectively, in which it called for a renewed focus on and intensified efforts for eliminating obstetric fistula. With each resolution, States reaffirmed their obligation to promote and protect the rights of all women and girls and to contribute to efforts to end fistula, including the global Campaign to End Fistula.

14. In October 2012, the Human Rights Council adopted resolution 21/6 on preventable maternal mortality and morbidity and human rights, in which it supported the application of a human rights-based approach to policies and programmes to reduce maternal mortality and morbidity, including fistula. The resolution follows previous Human Rights Council resolutions related to the issue, including resolutions 11/8, 15/17 and 18/2.

15. In the agreed conclusions adopted at its fifty-eighth session in March 2014, the Commission on the Status of Women noted that progress towards reducing maternal mortality and morbidity had been slow and uneven. The Commission considered that levels of preventable maternal deaths and morbidity, including obstetric fistula, especially for adolescent girls, were still unacceptably high and highlighted significant gaps in funding for sexual and reproductive health.

16. At its forty-seventh session in April 2014, the Commission on Population and Development assessed the status of the implementation of the Programme of Action of the International Conference on Population and Development, 20 years after the Conference. The Commission adopted resolution 2014/1, in which it emphasized that particular attention should be given to the elimination of preventable maternal mortality and morbidity through, inter alia, strengthening of health systems, and ensuring equitable and universal access to quality, integrated and comprehensive sexual and reproductive health services.

B. Major regional initiatives

17. Road maps have been established to help Governments strengthen health systems and to plan and mobilize support for skilled attendance during pregnancy, childbirth and the postnatal period.[10] With support from the United Nations and other partner organizations, 43 African countries have developed road maps to accelerate the reduction of maternal mortality and have included maternal, newborn and child health issues in their poverty reduction strategies and health plans. Of these countries, 35 have developed operational plans for maternal and newborn

[9] WHO, *Trends in Maternal Mortality: 1990 to 2013 — Estimates by WHO, UNICEF, UNFPA, the World Bank and the United Nations Population Division* (Geneva, 2014).

[10] See, for example, WHO Regional Committee for Africa resolution AFR/RC54/R9 of 3 September 2004.

health at the district level.[11] In July 2014, with a view to intensifying the efforts needed to achieve Millennium Development Goal 5, a coalition of United Nations organizations which support maternal and child health developed a new acceleration road map, aimed at enhancing support for countries and thereby saving the lives of an additional 140,000 women and 250,000 newborn children by the end of 2015.[12] The road map represents a vision of how well-planned financing, cooperation and coordination can ultimately lead to the elimination of all preventable maternal mortality and morbidity, including obstetric fistula, in high-burden countries.

18. In 2006, at its eighth ordinary session, the Executive Council of the African Union endorsed the Continental Policy Framework on Sexual and Reproductive Health and Rights. The framework, known as the Maputo Plan of Action for the Operationalization of the Continental Policy Framework on Sexual and Reproductive Health and Rights, addresses reproductive health challenges in Africa and contains a substantial component on obstetric fistula, which calls for strengthening of the health sector and increased resource allocations to health. While some progress has been made in implementing the Maputo Plan of Action, resources remain very limited, with few countries having a budget line for sexual and reproductive health. Not all countries have recommitted to the extension of the Maputo Plan until 2015 to coincide with the targets of the Millennium Development Goals, but a comprehensive five-year review of the status of the implementation is to be submitted to the African Union Commission in early 2015.[13]

19. The Campaign on Accelerated Reduction of Maternal Mortality in Africa promotes the intensified implementation of the Maputo Plan of Action. The United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO), as well as donors and civil society organizations, provide support for the campaign at the national and regional levels. Numerous strategic policy dialogue and advocacy activities have been conducted since its launch. In 2013, the Campaign was launched in Comoros, Côte d'Ivoire, Guinea, Mali and Seychelles. In addition, significant support and advocacy efforts were undertaken at the regional level to ensure the inclusion of reproductive maternal, newborn and child health in the post-2015 development agenda. Djibouti, Madagascar, Somalia and South Sudan were among the countries that launched the Campaign in 2014.

20. A regional fistula meeting organized by UNFPA in Senegal in 2013 brought together representatives of nine ministries of health,[14] fistula treatment centres, civil society organizations and professional associations from West and Central Africa. The objective of the meeting was to promote a more conducive and enabling environment to end obstetric fistula. Consensus was reached on key actions, including: a shift from a campaign model towards a more sustainable approach of integrating obstetric fistula services into maternal health services; provision of support to national capacity-building for the prevention and management of

[11] Triphonie Nkurunziza and others, "Progress report on the road map for accelerating the attainment of the Millennium Development Goals relating to maternal and newborn health in Africa", *African Health Monitor*, No. 18 (WHO Regional Office for Africa, November 2013).

[12] United Nations, "Road map to accelerate achievement of maternal and newborn survival and reach Millennium Development Goals 4 and 5 (targets A and B)" (June 2014). Available from www.mdghealthenvoy.org/news/documents/.

[13] http://pages.au.int/carmma/documents/maputo-plan-action-5-year-review.

[14] Benin, Burkina Faso, Cameroon, Chad, the Congo, Guinea, Mauritania, the Niger and Senegal.

obstetric fistula; and increased advocacy efforts for resource mobilization at the national and international levels.

21. In the Arab States, Djibouti, Somalia, the Sudan and Yemen are working towards the prevention, management, surgical treatment and rehabilitation of women with obstetric fistula. In Djibouti, United Nations organizations are supporting two maternal health service centres to provide emergency obstetric and newborn care, improve post-partum care and expand the midwifery workforce. The Government, with the support of United Nations organizations and other partners, is planning to gather concrete data on the prevalence of fistula in order to estimate the magnitude of the problem. Somalia has a high incidence of obstetric fistula, and its main focus is on increasing the number of births attended by skilled personnel and on strengthening the human resources for health, including capacity-building for surgeons to master the techniques of fistula repair. In Yemen, United Nations organizations and development partners have provided support for the establishment in public hospitals of two centres for the surgical treatment of fistula and for the training of service providers for the centres.

22. In Latin America and the Caribbean, the Regional Inter-Agency Task Force for the Reduction of Maternal Mortality is a key player in coordinating regional strategies for maternal and newborn health. Several countries, including Argentina, Brazil, Colombia and El Salvador, have begun to develop and implement maternal morbidity surveillance systems. Regional standards for intercultural maternal health care are under development, with the aim of establishing a set of standard care protocols that can inform national norm-setting processes. This strategy facilitates government ownership of the process, while offering opportunities for South-South collaboration. In addition, to strengthen midwifery professional organizations in the region, Argentina, Ecuador, Guyana, Haiti, Paraguay, Suriname, Trinidad and Tobago and Uruguay are using the Member Association Capacity Assessment Tool, which was developed by the International Confederation of Midwives and partners as part of their strategic planning process. In the Caribbean, an additional six countries have developed comprehensive national sexual and reproductive health policies. Regional studies on adolescent pregnancies and local legislation that hampers access to reproductive health services for adolescents are currently in the planning phase.

23. South-South collaboration is promoted as a key strategy to ending obstetric fistula. In 2013, a national strategy outline on obstetric fistula was shared by Rwanda with Zambia and Eritrea. The Midwives Association of Ethiopia and the Midwives Association of Ghana have launched a twinning relationship to promote mentorship and facilitate increased sharing of knowledge and best practice; midwifery students from South Sudan are being trained in Uganda; and Afghanistan has collaborated with the Islamic Republic of Iran on a review of the midwifery training programme and curricula. Examples of partnerships and collaborations also include the fourth International Roundtable on China-Africa Health Cooperation, held in Gaborone in May 2013, followed by the convening of the Ministerial Forum on China-Africa Health Development in Beijing in August 2013. These initiatives have contributed to the mobilization of political and financial support for sexual and reproductive health and reproductive rights in Africa, including fistula prevention, repair and reintegration.

C. Major national initiatives

24. Countries are making progress in reducing maternal mortality and morbidity. Some 19 countries, including Cambodia, Equatorial Guinea, Eritrea, Nepal, Rwanda and Timor-Leste, have already achieved a 75 per cent reduction in their respective maternal mortality ratios between 1990 and 2013, reaching the Millennium Development Goal 5 target before 2015. Among countries that had a maternal mortality ratio of less than 100 in 1990, progress has been made in Chile (60 per cent reduction), China (67 per cent), the Islamic Republic of Iran (72 per cent), Jordan (42 per cent), Libya (52 per cent), Mexico (45 per cent), Qatar (51 per cent), Saudi Arabia (61 per cent) and the United Arab Emirates (53 per cent).[9] Notwithstanding the remarkable gains made in reducing maternal morbidity and mortality and in improving reproductive health, there are continuing challenges that need to be addressed.

25. Improving sexual and reproductive health must be a country-owned and country-driven process. Countries need to allocate a greater proportion of their national budgets to health, with additional technical and financial support provided by the international community. Progress has been made in integrating obstetric fistula into the national health policies and plans of countries such as Bangladesh, Burkina Faso, Ghana, Guinea, Guinea-Bissau, Mali, Madagascar, Mozambique, Sierra Leone, the Sudan and Uganda. In Afghanistan, the revised reproductive health policy and strategy focuses on male involvement, emergency obstetric care, fistula and gender-based violence. In 35 fistula-affected countries, with Ghana recently joining the list, a national task force for fistula has been established to promote national leadership and ownership and serve as a coordinating mechanism for the activities of fistula partners nationwide. In addition, 33 countries have integrated prevention, management and treatment of fistula into their training curricula for health workers.[15]

26. Several countries are using innovative approaches that are generating positive results to raise awareness and increase access to treatment. Sierra Leone established a toll-free hotline to provide information about fistula and the availability of treatment. The initiative has contributed to a significant increase in the number of women referred to and treated at Aberdeen Women's Centre. Toll-free hotlines also exist in Burundi (in partnership with Médecins sans frontières, Belgium), Cambodia and Kenya. In the United Republic of Tanzania, the mobile phone-based money transfer microfinancing service known as M-PESA, established in 2009, covers the transportation costs of impoverished fistula patients, particularly those from the most remote and hardest-to-reach areas, so they can have access to fistula surgery. The system also provides free accommodation and meals before and after surgery, thereby addressing major barriers to accessing fistula treatment. In Kenya, the non-profit organization One by One is using digital pens to collect and store data about patients and their follow-up, thereby improving the quantity and quality of data captured for monitoring, evaluation and research purposes.

27. In Bangladesh, the Ministry of Health and Family Welfare endorsed the National Strategy on Obstetric Fistula in January 2014, with a costed action plan under development. The Government also announced the creation of 3,000 midwifery posts. About 70 per cent of births in Bangladesh take place at home, so

[15] www.endfistula.org/public/pid/7441?feedEntryId=26654.

the creation of the midwifery posts will result in increased skilled birth attendance, potentially contributing to the reduction of maternal mortality and morbidity, including obstetric fistula. In Nepal, to improve quality of care, the Ministry of Health and Population, with the support of United Nations organizations and partners, is developing a training site for obstetric fistula. In addition, with relatively little information available on reproductive health morbidities in Nepal, a study documenting the prevalence of selected morbidities, including obstetric fistula, was begun in early 2014. Findings from this study will form the basis for the development of national strategies to eradicate obstetric fistula and other morbidities.

IV. Actions taken by the International Community: remaining gaps and challenges

A. Prevention strategies and interventions to achieve maternal health goals and eliminate obstetric fistula

28. Three key evidence-based interventions are essential to prevent maternal deaths and disability, including fistula; namely: (a) family planning, (b) skilled birth attendance at every delivery and (c) access to emergency obstetric and newborn care, in the context of sexual and reproductive health services. In 2003, UNFPA and its partners launched the global Campaign to End Fistula, with the goal of making fistula as rare in developing countries as in the industrialized world. UNFPA serves as the secretariat of the International Obstetric Fistula Working Group, the main decision-making body of the Campaign to End Fistula. The Campaign focuses on three key strategies: prevention, treatment and social reintegration. It is active in over 50 countries in Africa, Asia, the Arab region and Latin America, and brings together more than 90 partner agencies at the global level and many others at the national and community levels. Since the launching of the Campaign, UNFPA has directly supported more than 47,000 fistula repairs, and non-governmental partners, such as EngenderHealth and Women and Health Alliance International, have supported thousands more.[16]

29. Midwives play a crucial role in preventing maternal and newborn mortality and morbidity, including obstetric fistula, by providing high-quality skilled delivery care, and identifying when a woman's labour is prolonged or obstructed and referring her to emergency obstetric care, as required. When properly trained and supported by a functional health system, midwives can provide 87 per cent of the essential care needed by women and their newborn children, which could potentially reduce maternal and newborn deaths by two thirds.[17] While in developing regions the proportion of births attended by skilled health professionals, including midwives, increased globally from 56 per cent in 1990 to 68 per cent in 2012, vast disparities across regions remain. The lowest levels (50 per cent or below) of skilled care are found in Africa and South Asia, although these regions have increased attendance by 10 percentage points or more since 2000. Low levels of coverage are compounded by significant inequities, with large urban-rural gaps: over 32 million

[16] http://www.endfistula.org/.

[17] UNFPA, International Confederation of Midwives and WHO, *The State of the World's Midwifery, 2014: A Universal Pathway. A Woman's Right to Health* (New York, UNFPA, 2014).

of the 40 million births that were not attended by skilled health personnel in 2012 occurred in rural areas.[18] Since 2008, UNFPA, the International Confederation of Midwives (ICM) and other partners, have provided support to more than 50 low-resource countries to build competent midwifery workforces and fill the human resource gap in maternal health and increase skilled attendance at all births. In 2012 and 2013, over 500 midwives were trained in fistula prevention and early management activities in countries such as Afghanistan, Ethiopia, Nepal, Uganda and Zambia. In 2013, Pakistan began a two-year degree programme in midwifery, with a curriculum based on ICM guidelines.

30. Midwives are the front-line workers in the fight to prevent obstetric fistula and maternal mortality and must therefore be well trained, supported and equitably deployed in areas in which their services are most needed. To help advocacy efforts with Governments to enhance and scale up investments in midwifery, UNFPA, ICM and WHO launched, the second State of the World's Midwifery report in June 2014.[17] The report contains the most recent midwifery data from 73 high maternal mortality countries which account for 96 per cent of all maternal deaths, 91 per cent of all stillbirths and 93 per cent of all newborn deaths but have only 42 per cent of the world's midwives, nurses and doctors. Using innovative multimedia e-learning, UNFPA, in collaboration with WHO, the Intel company and the health organization Jhpiego, is expanding outreach and improving the quality of midwifery training, particularly in lifesaving skills. Nine e-modules for front-line health workers have been developed, including a module for midwives on the management of prolonged obstructed labour, which is often the cause of fistula. Over 400 midwives were inducted in the use of these innovative training modules in 2013.

31. Several countries are implementing policies to reduce financial barriers to maternal health care. Examples include Sierra Leone and, more recently, Kenya, which have both officially abolished user fees. Universal and accessible quality reproductive health care has helped to eliminate obstetric fistula in developed countries, and the recently launched initiative, "Every Newborn: an action plan for ending preventable deaths",[19] led by WHO, UNICEF and partners, calls for universal coverage of high-quality care with innovation; accountability and data; leadership, governance, partnerships and financing; and review of global and national goals, targets and milestones (for the period 2014-2035). Such strategies not only address newborn health but also help to eliminate preventable maternal deaths and morbidities, including obstetric fistula.

32. The Health Four Plus initiative is a collaborative effort of six United Nations organizations (UNFPA, UNICEF, WHO, World Bank, Joint United Nations Programme on HIV/AIDS (UNAIDS) and United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women)). With the support of Governments, Health Four Plus is working in countries with high numbers of maternal and newborn deaths to accelerate progress to achieve Millennium Development Goals 4 and 5 by harnessing the collective power of each partner's strengths and capacities. At the country level, this programme seeks to increase equitable access to services for sexual, reproductive, maternal, child and newborn health, as well as prevent mother-to-child transmission of HIV by strengthening the health system and active community engagement.

[18] United Nations, *The Millennium Development Goals Report 2014* (New York, 2014).

[19] http://www.who.int/maternal_child_adolescent/topics/newborn/enap_consultation/en/.

33. Family planning is crucial for preserving the lives and health of women and newborn children. It is estimated that contraceptive use has reduced maternal mortality by over 40 per cent.[20] It may also contribute to reducing the risk of recurrence of fistula in future pregnancies of fistula survivors. The International Conference on Family Planning, organized around the theme "Full access, full choice" and held in Addis Ababa in November 2013, underscored the important role of family planning in addressing maternal mortality and morbidity.[21] A steady and reliable supply of maternal health medicines is essential to saving lives during pregnancy and childbirth. The UNFPA Global Programme to Enhance Reproductive Health Commodity Security procures essential supplies that save lives before, during and after pregnancy in high-burden countries. Since 2012, significant progress has been made in enhancing the procurement of reproductive health supplies as well as the capacity of national health systems to manage these supplies and to provide related services for family planning and improving maternal health. In 2013, seven life-saving maternal health medicines were available at more than 70 per cent of service delivery points in nine countries with high maternal mortality and morbidity.[22]

34. Women living with or recovering from fistula are often neglected and stigmatized. Most women who develop fistula remain untreated for the remainder of their lives, and the condition can easily recur in women whose fistula has been surgically treated but who receive little or no medical follow-up and then become pregnant again. Governments need to develop and strengthen systematic registration and tracking mechanisms for each woman and girl who has or has had an obstetric fistula in order to help prevent recurrence and ensure the survival and well-being of both mother and baby in subsequent pregnancies.

35. Raising awareness, and sensitizing and mobilizing communities are essential strategies for preventing fistula and maternal and newborn death and disability. Fistula survivors are key advocates in this effort. For example, in Ethiopia, the organization Healing Hands of Joy trains former fistula patients as safe motherhood ambassadors who educate women about antenatal care and safe delivery, contributing to an increase in health facility deliveries. The organization also focuses on the reintegration of fistula survivors through activities such as microloan programmes which provide economic opportunities for women to pay off medical expenses and support themselves and their families. One programme in particular, a beekeeping and honey production project, allows women who continue to suffer from incontinence to receive an income and become self-sufficient.[23]

B. Treatment strategies and interventions

36. While global progress is being made to increase access to fistula treatment for those women and girls in need of it, it is vastly insufficient. In 2013, more than 10,000 fistula surgeries were directly supported by UNFPA, a significant increase

[20] Saifuddin Ahmed and others, "Maternal deaths averted by contraceptive use: results from a global analysis of 172 countries", *The Lancet*, vol. 380, No. 9837 (14 July 2012), pp. 111-125.

[21] www.fpconference2103.org.

[22] Guinea, Haiti, Honduras, Liberia, Mali, Mozambique, the Niger, Sierra Leone and Timor-Leste.

[23] Healing Hands of Joy, *2013 Annual Report*. Available from http://healinghandsofjoy.com/images/stories/2013_hhoj_report.pdf.

from 2012, especially in countries such as Uganda, where over 1,436 women were surgically treated during the year, and Nigeria, in which there were about 6,000 fistula repairs in 2013, compared with 2,000 in 2008. Yet, tragically, only a fraction of those in need of treatment actually receive it. The International Federation of Gynaecology and Obstetrics, the International Society of Obstetric Fistula Surgeons and the Fistula Foundation have implemented a competency-based fistula surgery training programme to expand global treatment capacity. A dramatic and sustainable scaling-up of quality treatment services and trained and competent fistula surgeons is needed. Closing this gap should be a high priority in the global post-2015 development agenda.

37. To promote increased access to quality fistula treatment and care, two innovative fistula repair kits were launched by UNFPA and the International Society of Obstetric Fistula Surgeons. These kits provide high-quality instruments and specialist materials for surgical fistula repairs, as well as a high-quality, specialized operating table. In 2013, the pharmaceutical company Johnson & Johnson announced a donation of sutures for the kits, which will facilitate the treatment of 15,000 women with obstetric fistula.

38. Lack of awareness that treatment for fistula is possible and available and the high cost of accessing that treatment constitute major barriers to caring for women and girls suffering from fistula. Countries should make every effort to make fistula services accessible to all who need them, including through the provision, in strategically selected hospitals, of integrated fistula services which are available continuously and provide the full continuum of holistic care and support for the treatment, rehabilitation and vital follow-up of fistula survivors.

C. Reintegration strategies and interventions

39. To fully recover and heal from obstetric fistula requires not only medical or surgical treatment but also a holistic approach that addresses the psychosocial and socioeconomic needs of the survivors. Follow-up of fistula patients is a major gap in the continuum of care. Tragically, only a fraction of fistula patients are offered reintegration services in most settings, despite significant needs. All fistula-affected countries should track this indicator to ensure access to reintegration services; some countries are already using it to track progress in this area. In 2013, all surgically treated women in Chad were offered reintegration services, as were most of the women who underwent surgery in Sierra Leone. Intensive social reintegration of women and girls deemed inoperable or incurable remains a major gap.

40. Reintegration services must be holistic, comprehensive, continual and available for as long as needed. They should include counselling and follow-up throughout all phases of treatment and recovery, from the first point of contact to post-discharge from hospital, health education, family planning and income-generating activities, combined with community sensitization to reduce stigma and discrimination. Connecting fistula patients to income-generating activities provides a much needed livelihood, renewed social connections and a sense of purpose. Fistula Foundation Nigeria offers a model programme whereby fistula survivors, including those deemed inoperable and incurable, are provided with ongoing counselling, support and livelihood training and opportunities, as well as long-term follow-up to ensure their survival and well-being. In the Congo, a special focus has

been placed on the crucial component of psychosocial rehabilitation and support of survivors, with activities that feature development of a support guide for social workers and establishment of a network of fistula survivors at the community level. All fistula survivors should universally be offered social reintegration services. Yet in reality, in several countries, many survivors are deprived of such services.

D. Research, data collection and analysis

41. Obtaining robust and comprehensive data on fistula remains a challenge, particularly given the invisibility of fistula survivors and the lack of priority and resources accorded the issue at the global and national levels. Progress has been made in improving the availability of data, including the development and application of a standardized fistula module for inclusion in demographic and health surveys in an increasing number of countries, such as Benin, Cameroon, Chad, Cote d'Ivoire, Guinea, Guinea-Bissau, Haiti, Kenya, Mali, the Niger, Sierra Leone, Togo, Yemen and Zambia. In addition, the Global Fistula Map, launched in 2012, has been updated, enhanced and expanded, and provides a snapshot of the landscape of fistula treatment capacity and gaps worldwide. The Map reveals a severe lack of fistula treatment centres in countries which have the highest levels of maternal mortality and morbidity. Data gathered show that, while the availability of surgical treatment for obstetric fistula is growing, only a fraction of fistula patients receive treatment annually.

42. Responding to the call for cost-effective methods for obtaining solid data on fistula, a new model to estimate the incidence and prevalence of obstetric fistula in countries has recently been developed by researchers at the Johns Hopkins Bloomberg School of Public Health. In addition, to assess the relationship between surgical and treatment outcome and long-term quality of life, health, psychosocial and reintegration outcomes following fistula surgery, Johns Hopkins University, together with UNFPA, WHO and the MacArthur Foundation, is conducting a multi-country study. This landmark study has been completed in Bangladesh and is ongoing in Ethiopia, the Niger and Nigeria. The results of the study will assist in the development of a prognostic-based classification system for obstetric fistula, guide advocacy and inform cost-effective programmes and national strategies. Nevertheless, more research is needed to address effectively the problem of obstetric fistula.

43. Maternal death surveillance and response, a framework directed at preventable maternal mortality and morbidity, is increasingly being promoted and institutionalized in several countries. Maternal death and severe morbidity near-miss case reviews[24] are of crucial importance in improving the quality of obstetric care, which, in turn, prevents the occurrence of obstetric fistula. Inter-agency consultations, as part of the WHO Commission on Information and Accountability, have been organized in all regions to address the need for widespread

[24] Near-miss reviews are performed after the occurrence of a life-threatening event in which a woman is deemed to have nearly died owing to a complication that occurred during pregnancy, childbirth or within 42 days of termination of pregnancy. See WHO, *Evaluating the Quality of Care for Severe Pregnancy Complications: The WHO Near-miss Approach for Maternal Health* (Geneva, 2011). Available from http://whqlibdoc.who.int/publications/2011/9789241502221_eng.pdf).

institutionalization of maternal mortality and morbidity surveillance and response systems, and a technical framework to support countries in the implementation of the maternal death surveillance and response was developed and published in 2013.[25] Some 14 African countries, including Benin, Burundi, Eritrea, Ethiopia, Guinea, Ghana, Madagascar, Malawi, Mozambique and Rwanda, are moving towards systematic maternal death and severe morbidity case reviews to improve quality of care. In Bangladesh and Nepal, a national surveillance system is being initiated with the support of UNFPA to identify and treat hidden fistula cases.

44. To prevent the occurrence of obstetric fistula, timely access to quality emergency obstetric services is of paramount importance. To this end, it is essential to assess the current level of care and provide the evidence needed for planning, advocacy and resource mobilization in order to scale up such emergency services in every district. UNFPA, UNICEF, WHO and the Averting Maternal Death and Disabilities Programme at Columbia University in New York support emergency obstetric and newborn care needs assessments in countries with high rates of maternal mortality and morbidity. By 2014, some 30 countries with high maternal mortality rates had completed or initiated such assessments. Almost all of them have translated their survey findings into action plans, and seven are monitoring the progress made in relation to emergency obstetric and newborn care signal functions and the availability of skilled staff.

45. The Fistula Care project, led by EngenderHealth, completed a number of research studies on fistula. These studies have contributed to important findings on a community screening model for fistula in Nigeria; the documenting of a successful midwifery training facility (Aberdeen Women's Centre) in Sierra Leone; and a systematic review of the literature on the factors that influencing urinary fistula repair outcomes in developing countries. Another important multi-country research study, conducted through the Fistula Care project in collaboration with the United Nations Development Programme, UNFPA, UNICEF, WHO, the World Bank and the joint Special Programme of Research, Development and Research Training in Human Reproduction, showed that short-term (7 days) draining of the bladder with a catheter is as effective as longer term (14 days) catheterization for fistula repairs. This finding has major implications for reducing the risk of hospital infections, reducing costs and increasing the turnover of patients awaiting surgery repair.

E. Advocacy and awareness-raising

46. Over the past two years, sustained presence in the media, increased collaboration at the country and regional levels and enhanced coordination with partners has helped to ensure strong messaging and significant communications activities related to obstetric fistula. Efforts were made to mobilize countries in heavily affected regions, especially in Africa, with tailored tools, such as public service announcements and animations, some of which were translated into several local languages. To facilitate media and donor outreach and provide resources for more cohesive messaging around fistula, factsheets on key issues were developed, technically revised, widely shared and added to online resource kits.

[25] WHO and others, *Maternal Death Surveillance and Response: Technical Guidance Information for Action to Prevent Maternal Death* (Geneva, WHO, 2013). Available from http://apps.who.int/iris/bitstream/10665/87340/1/9789241506083_eng.pdf.

47. In 2013, the United Nations marked the first International Day to End Obstetric Fistula (23 May) with a special event at United Nations Headquarters. The historic occasion was commemorated with parallel activities by national authorities and Campaign to End Fistula partners throughout the world. In many countries, political leaders, first ladies, celebrities, health professionals and civil society organizations took part in the related events which featured awareness-raising and media outreach, as well as testimonies from fistula survivors on radio and television. Key messages called for fistula prevention and access to treatment and intensified actions aimed at ending obstetric fistula.

48. In 2014, the international community again commemorated the International Day to End Obstetric Fistula under the theme "Tracking fistula — transforming lives", reflecting the priority of strengthening the partnership to ensure that every woman in need of fistula-related services and follow-up is reached. Worldwide activities included global calls for accelerated action to end obstetric fistula and the inclusion of elimination of fistula in the post-2015 development agenda. Campaign partners launched a special documentary film, *mFistula*, which highlighted the power of mobile technology to reach poor and remote fistula survivors to enable them to access treatment and care.

F. Global financial and intensified support

49. A major challenge facing countries is the insufficiency of national financial resources for maternal health and obstetric fistula. The problem is compounded further by the low levels of official development assistance directed towards Millennium Development Goal 5. Contributions to the Campaign to End Fistula are vastly insufficient to meet needs and have steadily declined in recent years, in part because of the global financial crisis. An urgent redoubling of efforts is required to intensify resource mobilization in order to ensure that fistula does not once again become a neglected issue.

50. Efforts to end obstetric fistula are integrated into and supported by initiatives with a broader maternal health focus. These include the Muskoka Initiative: Maternal, Newborn and Under-Five Child Health, the Partnership for Maternal, Newborn and Child Health, actions supported through Health Four Plus and the Maternal Health Thematic Fund of UNFPA. The initiatives of the Campaign on Accelerated Reduction of Maternal Mortality in Africa and "Every woman, every child" continue to represent a key platform for the operationalization of the Global Strategy for Women's and Children's Health, including action on obstetric fistula.

51. Member States, the private sector and the general public continue to contribute to efforts to end fistula. In 2013, the Campaign to End Fistula received funding from private citizens, philanthropic foundations, such as Zonta International, and private corporations, including Johnson & Johnson, Total, Noble Energy, Virgin Unite and the MTN Foundation. In addition, private sector partners mobilized their media and communication platforms and creative teams to support fistula advocacy and events, in particular the first International Day to End Obstetric Fistula.

52. Despite the expanding partnership and technological advances, vastly inadequate external and domestic resources continue to hamper significantly the effectiveness of the response to obstetric fistula. While prevention of obstetric fistula is increasingly integrated into maternal health interventions, the significant

backlog of women and girls awaiting treatment requires urgent prioritization of what is a neglected population. What remains now is to ensure adequate financing to meet the goal of ending obstetric fistula.

V. Conclusion and recommendations

53. Obstetric fistula is an outcome of socioeconomic and gender inequalities and the failure of health systems to provide accessible, equitable, high-quality maternal health care, including family planning, skilled attendance during childbirth, and emergency obstetric care in case of complications. Over the past two years, considerable progress has been made in focusing attention on maternal deaths and disabilities, including obstetric fistula. Despite these positive developments, many serious challenges remain. It is a human rights violation that, in the twenty-first century, the poorest, most vulnerable women and girls suffer needlessly from a devastating condition that has been virtually eliminated in other parts of the world. It is imperative that the international community act urgently to end preventable maternal and newborn mortality and morbidity, including obstetric fistula.

54. Significantly intensified political commitment and greater financial mobilization are urgently needed to accelerate progress towards eliminating this global scourge and closing the gap in the unmet need for fistula treatment. There is an urgent and ongoing need for committed, multi-year, national and international support to provide the resources necessary to reach all women and girls suffering from this condition and to ensure sufficient, sustainable and continued programming. Special attention should be paid to intensifying the provision of support to countries with the highest maternal mortality and morbidity levels. This will enable such countries to provide free access to fistula treatment services, given that most fistula survivors are poor and cannot afford the cost of treatment.

55. Better understanding of the social and economic burden resulting from poor reproductive health, including maternal and newborn health, has led to multisectoral approaches to address the linkages among poverty, inequity, gender disparity, discrimination, poor education and health. Efforts to improve women's health should systematically include education of women and girls, economic empowerment, including access to microcredit and microfinance, and legal reforms and social initiatives that would increase the age of marriage and delay early pregnancy. It is essential that these issues be emphasized in the post-2015 development framework.

56. There is a global consensus on the key interventions necessary to reduce maternal deaths and disabilities in the context of sexual and reproductive health services. There is an urgent need to scale up the three well-known, cost-effective interventions, emphasizing the crucial role of midwives to reduce the high number of preventable maternal deaths and disabilities.

57. The following specific, critical actions, within a human rights-based approach, must be taken urgently by Member States and the international community to end obstetric fistula:

Prevention and treatment strategies and interventions

(a) Greater investment in strengthening health systems, ensuring adequately trained and skilled human resources, especially midwives, obstetricians, gynaecologists and doctors, and provision of support for the development and maintenance of infrastructure. This includes investment in referral mechanisms, equipment and supply chains to improve maternal and newborn health services, with functional quality control and monitoring mechanisms in place for all areas of service delivery;

(b) Development or strengthening of comprehensive multidisciplinary national action plans, policies, strategies and budgets for eliminating obstetric fistula that incorporate prevention, treatment, socioeconomic reintegration and essential follow-up services;

(c) Establishment or strengthening of the national task force for obstetric fistula, led by ministries of health, to enhance national coordination and improve partner collaboration;

(d) Ensuring equitable access and coverage, by means of national plans, policies and programmes, to make maternal health services, particularly family planning, skilled birth attendance and emergency obstetric and newborn care and obstetric fistula treatment, geographically, financially and culturally accessible;

(e) Ensured and improved access to the full continuum of care, particularly in rural and remote areas, through the establishment and distribution of health-care facilities and trained medical personnel, collaboration with the transport sector to provide affordable transport options, and promotion and support of community-based solutions;

(f) Increased availability of trained, skilled fistula surgeons and permanent, holistic fistula services integrated into strategically selected hospitals, accompanied by quality control to ensure that only skilled fistula surgeons provide treatment to address the significant backlog of women awaiting care;

Financial support

(g) Increased national budgets for health, ensuring that adequate funds are allocated to sexual and reproductive health, including obstetric fistula;

(h) Incorporation into all sectors of national budgets of policy and programmatic approaches to redress inequities and reach poor, vulnerable women and girls, which should include the provision of free or adequately subsidized maternal and/or newborn health-care services and obstetric fistula treatment to all those in need;

(i) Enhanced international cooperation, including intensified technical and financial support, in particular to high-burden countries, to accelerate progress towards eliminating obstetric fistula and improving maternal health;

(j) Mobilization of public and private sectors to ensure that needed funding is increased, predictable and sustained;

Reintegration strategies and interventions

(k) Ensuring that all women who have undergone fistula treatment have access to social reintegration services, including counselling, education, skills development and income-generating activities;

(l) Ensuring that the special needs of women and girls deemed incurable or inoperable are met, in addition to providing other essential reintegration services;

(m) Development and strengthening of follow-up mechanisms, including indicators to track the fistula survivor's access to reintegration services;

Advocacy and awareness-raising

(n) Strengthening of awareness-raising and advocacy, including through the media, to effectively reach families and communities with key messages on fistula prevention, treatment and social reintegration;

(o) Mobilization of communities, including local religious and community leaders, women, men, girls and boys to advocate for and support universal access to sexual and reproductive health, ensuring reproductive rights, reducing stigma and discrimination, promoting gender equality and empowerment of women and girls, ending violence against women and girls and preventing child marriage, recognizing that the well-being of women and girls has a significant positive effect on the survival and health of children, families and societies;

(p) Empowerment of obstetric fistula survivors to contribute to community sensitization and mobilization as advocates for fistula elimination and safe motherhood;

(q) Strengthened and expanded interventions to keep girls in school, especially post-primary and beyond, ending child marriage and protecting and promoting gender equality and the empowerment of women and girls. Laws prohibiting child marriage must be adopted, enforced and followed by innovative incentives for families to avoid marrying off girls, including those in rural and remote communities, at early ages;

(r) Development of linkages and engagement with civil society organizations and women's empowerment groups to help eliminate obstetric fistula;

Research, data collection and analysis

(s) Strengthened research, data collection, monitoring and evaluation, including up-to-date needs assessments, on emergency obstetric and newborn care, to guide the planning and implementation of maternal health programmes, including those for obstetric fistula;

(t) Development, strengthening and integration within national health information systems of routine reviews of maternal deaths and near-miss cases, as part of a national maternal death surveillance and response system;

(u) Development of a community- and facility-based mechanism for the systematic notification of obstetric fistula cases to ministries of health and their recording in a national register, and acknowledgement of obstetric fistula as a nationally notifiable condition, triggering immediate reporting, tracking and follow-up.

58. The challenge of putting an end to obstetric fistula continues to require vastly intensified efforts at the national, regional and international levels. These efforts must include strengthening of health systems, gender and socioeconomic equality, empowerment of women and girls, and promotion and protection of their human rights. Substantial additional resources need to be forthcoming to accelerate progress, and funding must be increased. As the international community moves towards the post-2015 development framework, significantly enhanced support should be provided to countries, United Nations organizations, the Campaign to End Fistula and other global initiatives dedicated to improving maternal health and eliminating obstetric fistula.